

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 11, 2003
10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public comment

MR. HACKBARTH: That's it for today, except for the public comment period. Do we have any public comments?

MS. FISHER: I see I have a lot more time than normal.

[Laughter.]

MR. HACKBARTH: Karen, it just wouldn't be fair to the staff if we didn't treat you the same way.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges.

I hope that you will indulge with me and bear with me for a second to talk about the cost to charge issue. I know it's dense, but it's also very important as we've learned from the outlier issue.

Jack accurately pointed out the impact of what can happen with how costs and charge markups occur and can result in overpayments. But I'd like to point out the fact that it's important to recognize that it can also result in underpayments.

I'd like to use the outpatient system as an example because the outpatient system is done, the payments are based more on a service level, a lot less bundling than the inpatient side.

We have heard from a number of our members that in terms of markups that they will, for various reasons, oftentimes on the commercial side, will have a lower markup for high cost item than they will for a low-cost item. So they will have a sliding scale of a markup system because for a very high cost item they cannot mark it up 50 percent.

If that isn't the case, when you go to convert the charges of that high-cost item into cost, and you're using a cost-to-charge ratio that, for example, was based on the lower cost higher markups, let's say a 50 percent markup, where the high-cost item is really only marked up 10 percent, the result is you're going to obtain a cost for that item that is lower than that actually is.

The result is that if it goes into the system that for some high-cost APCs, the APC payment rate, through no fault of the technical system of doing the payment rates, can be inadequately low because the costs you've derived are not the actual costs of the service. And I think that's important to recognize as you go in to do the study, the impacts of that.

That can also occur on the inpatient side.

Let me back up on the outpatient side. Do we really care about that? Not really if you're overpaying for the low cost items. In theory, if it was evenly set up, you have the overpayments and the underpayments offsetting each other. To be honest with you, I'm not sure how much I would care as a hospital.

The problem is if the underpayment is happening on the high-cost side, you need a fair amount of overpayment on the low-cost side to offset the underpayment.

So I think that's an issue that, as the staff does the

analysis, it's important to look into.

On the inpatient side, it probably matters a little bit less because the payments are bundled. But I will say, and some of you will like the fact that I am going to circle around to IME on this, that if it does hold true, just hypothetically, and if you believe the teaching hospitals tend to have the high-cost items which they may be marking up less, theoretically potentially the cost per case that you may have at a teaching hospital could be, on the books, lower than it actually is. We don't know that because the only data that's used is the Medicare cost report data and we're converting.

So when you look at a comparison of teaching hospital's cost per case to non-teaching hospital's cost per case, there could be a gap there that is less than it is in actuality.

The problem with all of this, I think it's a nice intellectual discussion, is it's very difficult to get at this. But I think with some of the work that's being done, GAO has been doing it, and some of the work the staff has been doing, I think we'll get at some of these items. But I thought it was useful to point out.

Thank you for your time.

MR. HUNTER: Mr. Chairman, I will try to be as quick as I can. Justin Hunter from Powers, Pyle, Sutter and Verbile. I am here today wearing two hats. My first hat is on behalf of Forsynius Medical Care, a supplier and provider of dialysis supplies and services.

Forsynius would respectfully urge the Commission to take into account transparency and accuracy as part of any rate setting procedures that occur within the ESRD program as part of a new payment framework or structure. And in that regard, we would further urge you to consider examining some of what we believe are outdated cost reporting rules that oftentimes can have the arbitrary effect of denying service-related costs and treatment-related costs. Hopefully, as part of any new framework policy recommendations that you all devise, that will include an examination of these outdated cost reporting rules.

Ms. Ray, and I want to get to a second issue that Ms. Ray pointed out in her presentation of the ESRD issues, particularly the statement that on the non-composite rate side, or the drug reimbursement or separately reimbursable side, there is a phenomena of overpayment. I don't think anyone in the industry would deny that. That has been widely recognized by the industry. It's been widely recognized in the past by this commission.

I think it's very important to redirect your attention to the fact is that the reason for that is the underpayment on the composite rate side. Obviously, you all are going to be considering and examining HHS's recent report that took into account and formulated actually a market basket index for the composite rate. That report is 60-some-odd pages and I would just cut right to the chase in terms of what we believe is one of its most important aspects.

A market basket index was formulated as part of that report. The data was backed up to 1996 and run through 2002. It

indicated that the composite rate increase or the cost associated with the composite rate, excuse me, increased during that time period by over 20 percent. I believe it was 20.2 percent. It's been a while since I've looked at the numbers, but I believe that's it.

As Dr. Hakim indicated earlier today, during that same time period the 3.6 percent composite rate increase that he mentioned is what was experienced in the industry. Now I have not had an opportunity to look at what MedPAC's composite rate increase data showed during that time period, but I suspect that it would not vary much if at all.

And we would urge you all to seriously consider the data and the framework that is contained in that report as far as a composite rate, or market basket composite rate framework is concerned.

It is worth mentioning and should be underscored, in fact, that the composite rate for the ESRD program was the first prospective payment system that was created under Medicare. And it remains the only prospective payment system in Medicare that does not have a market basket increase framework.

Consequently, the industry is forced to trudge to Capitol Hill increasingly single year and say give us a composite rate increase. It's not lost upon any of us that we look oftentimes to the work and recommendations of this commission in doing that. We believe that we should be treated like every other provider. And we appreciate the recommendations that you all have made in the past with respect to empowering CMS to provide a market basket index framework for an update.

I will change hats real quickly and go to an issue that concerns the Association of Freestanding Radiation Oncology Centers.

It struck me that during the course of the SNF discussion, with respect to access to services, that it might be worth mentioning an issue to you. It's a small one but since you're going to be looking at access, it's worth mentioning.

As part of the PPS for SNFs, when a nursing home sends their patients to receive care off campus, outside of their facility, in an attempt to ensure that the SNF is not trying to get out of its obligation to provide care, there's a definition of resident for the SNF patient. And with respect to outpatient radiation oncology services, a SNF is permitted to send their patient to a hospital-based center to receive those services.

And in that circumstance, the hospital can bill Medicare separately under Part B and the SNF is off the hook. If the SNF wishes to send that same patient across the street, down the road, where have you, to a freestanding radiation oncology center, the SNF is on the hook for the services and the freestanding oncology center, the non-hospital-based oncology center, cannot bill Medicare separately for that. They have to get their payment from the SNF.

Our members from AFROC are very concerned about this. They're frankly having trouble serving SNF patients. So I point that out for your attention and consideration.

Thank you for your time.

MR. HACKBARTH: Anyone else?

Okay, we're adjourned for today. For the commissioners, we have a breakfast at 8:15. It will be downstairs in the room where we had lunch.

The public session begins at 9:30 tomorrow.

[Whereupon, at 4:53 p.m., the meeting was recessed, to reconvene at 9:30 a.m., Friday, September 12, 2003.]